IRVING &
ASSOCIATES IN
BEHAVIORAL HEALTH, P.C.
5151 Mochel Drive, Suite 307
Downers Grove, IL 60515

AUTHORITZATION TO RELEASE INFORMATION

Patient Name: ____

Date of Birth: _______/_______/________ Social Security Number: _________-_______-_________

I/We authorize and request ____ release of confidential and professional information including personal, psychiatric, medical, laboratory, psychological testing data and interpretations, social, educational, substance abuse, clinical information, opinions, and/or any other information regarding contacts with myself to:

Name: ____

Address: ____

City/State/Zip: ____

Phone: ______________________________ Fax: ______________________________

I/We understand that my refusal to consent to release the information specified above will prevent disclosure of such materials to the person/facilities named herein, with the potential consequence of reduced accuracy and completeness of my case.

This release is valid through _____/______/______ unless dated as follows ____/______/______.

______________________________________ ______________________
Signature of Client (age 12 & older) Date

______________________________________ ______________________
Print Name of Client Date of Birth of Client

______________________________________ ______________________
Signature of Parent/Legal Guardian Relationship to Client